HEALTH CARE COMPLAINT FORM

COMMONWEALTH OF PENNSYLVANIA
OFFICE OF ATTORNEY GENERAL
www.attorneygeneral.gov

MIKE FISHER
Attorney General

RETURN TO:
BUREAU OF CONSUMER PROTECTION
HEALTH CARE UNIT
14th Floor, Strawberry Square
Harrisburg, PA 17120
Phone: (717) 705-6938
Fax: (717) 787-1190
Toll free in PA: 1-877-888-4877

OFFICE USE ONLY			
INVESTIGATOR:	COMPLAINT #:	Code 1	Code 2

YOUR AGE: (STATISTICAL & ENFORCEMENT PURPOSES ONLY)
☐ 18-29 ☐ 30-44 ☐ 45-59 ☐ 60 or older

YOUR NAME _____

HOME PHONE ( ) _____ – _____ **BEST NUMBER TO CALL DURING THE DAY** ( ) _____ – _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP CODE** _____ **COUNTY** _____

NAME OF PRIMARY BUSINESS COMPLAINT IS AGAINST _____

NAME OF INDIVIDUAL(S) TO WHOM YOU COMPLAINED _____

ADDRESS _____ **CITY** _____

STATE _____ **ZIP CODE** _____ **COUNTY** _____ **PHONE** ( ) _____ – _____

Provider Information	Managed Care/Health Insurance Information
Physician Name _____	Insurer/HMO, etc. _____
Physician Address _____	Insurer/HMO Phone No. _____
Physician Phone No. _____	Identification No. _____
Hospital Name _____	Group No. _____
Hospital Address _____	Subscriber Name _____
Hospital Phone No. _____	Patient's Name _____
Other _____	Patient's Relationship to Subscriber _____
	Patient's Date of Birth _____

FILING A COMPLAINT WITH THE OFFICE OF ATTORNEY GENERAL MAY NOT PRESERVE YOUR APPEAL RIGHTS, PURSUANT TO ACT 68 OR MEDICARE. TO PRESERVE YOUR RIGHTS, YOU MUST FILE ANY COMPLAINT OR GRIEVANCE APPEAL DIRECTLY WITH YOUR HEALTH PLAN OR IN CONFORMANCE WITH THE TERMS OF YOUR COVERAGE.

If you have filed an appeal or grievance with your Insurer/HMO, etc., please state when and the outcome _____

_____

Have you complained to any other state or federal agencies? _____

What action was taken? _____

Have you retained an attorney? ☐ Yes ☐ No? If yes, please provide your attorney's name, address, & telephone number _____

_____

Have you filed a court action? ☐ Yes ☐ No? If yes, please state **WHEN** _____ **WHERE** _____

DOCKET NO. _____ **WHAT DECISION WAS MADE?** _____

PLEASE COMPLETE THE REVERSE SIDE OF COMPLAINT FORM

IMPORTANT! PLEASE READ AND SIGN ATTACHED MEDICAL RELEASE/AUTHORIZATION

Please explain your complaint. You may use additional sheets, if necessary. Please write or type clearly. Try to be brief, but be sure to tell **WHAT** happened, **WHEN** it happened, and **WHERE** it happened. Be specific about any oral statements the business made to you, including , if possible, the names of individuals you allege to have made the statements. Describe events in the order in which they happened. Attach **COPIES** of all applicable insurance contracts or policies, medical bills, correspondence, receipts, canceled checks (front & back), advertisements or any other papers that relate to your complaint. Please be certain that the copies are **legible** and **labeled**. In addition, please be sure to sign and date the attached **"Authorization to Release Medical/ Insurance Records."** We will be unable to pursue your complaint if you neglect to sign and date the "Authorization." Your compliance with the above instructions will greatly facilitate the handling of your complaint.

What specific resolution are you seeking in order to settle your complaint?

PLEASE READ CAREFULLY

The Attorney General cannot act as your private attorney. As a law enforcement agency, the primary function of the Office of Attorney General is to represent the public at large by enforcing laws prohibiting fraudulent or deceptive trade practices. The information you provide will be used in an attempt to resolve your complaint and will be shared with the party(ies) against which the complaint is filed.

The Bureau of Consumer Protection, through the Health Care Unit, attempts to mediate individual complaints. Your complaint will remain on file with our office and the information contained in it may be used to establish violations of Pennsylvania Law.

I certify that the information provided is true and correct to the best of my knowledge, information and belief.

*Your Signature*_____ *Date*_____

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Authorization to Release Medical/Insurance Records

I, _____, hereby authorize any physician, medical practitioner, hospital or medically related facility, insurance company, managed care organization or other institution or person having any of my medical/insurance records to release all or any such medical/insurance records to the Office of Attorney General or its authorized representatives. The purpose of this disclosure is to allow the Office of Attorney General to investigate a complaint filed by me or on my behalf.

Medical records shall include all past, present, or future medical information or knowledge of medical information, medical reports, physical examination reports, hospital reports, opinions concerning my health, or x-ray reports relating to me or my health.

All persons to whom the confidential information is disclosed pursuant to my consent shall maintain the confidentiality of such information, and not disclose it to any other person in any form, without my prior written consent. This authorization is valid as long as my file is open and active in the Office of Attorney General. I also agree that a photocopy or facsimile of this authorization shall be as valid as the original.

Signature of Complainant _____

Social Security Number _____

Date _____

Bureau File #_____

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Specific Authorization To Release Substance Abuse Records

I hereby authorize _____ to release or disclose to the Office of the Attorney General or its authorized representatives, substance abuse treatment information and records. The purpose of the disclosure is to allow the Office of the Attorney General to investigate and research a complaint filed by me or on my behalf. I understand that my substance abuse records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically when my file is closed and inactivated by the Office of the Attorney General.

Signature of Complainant _____

Social Security Number _____

Date _____

Bureau File #_____

Bureau of Consumer Protection Health Care Unit
14th Floor, Strawberry Square•Harrisburg, PA 17120